In a more recent analysis, Langmuir and colleagues invoked a dual epidemic of influenza and toxigenic staphylococci.[3] Even that was questioned by Morens and Chu who blamed Rift Valley fever.[4]

Despite the sexual orientation of many Athenian and Spartan men at that time, one may be certain that the epidemic was not AIDS.

THEODORE B. MASSELL, MD
4822 Van Noord Ave
Sherman Oaks, CA 91423

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4. Morens DM, Chu MC: The plague of Athens (Correspondence). N Engl J Med 1986; 314:855

Cognitive Dissonance

TO THE EDITOR: A new disease has struck among surgical patients. It causes delay and postponement of timely surgery which extends the discomfort and disability of the disease that indicates surgery and increases the magnitude of the surgery ultimately required to control the disease. It is spread by third party payers.

The disease is *cognitive dissonance,* a term borrowed from the commercial literature. Another common term is "buyers remorse." The vector is the mandatory second opinion program which twists a time-honored feature of high-quality medical care into an instrument of parsimony. The pathways create a series of administrative hurdles which must be negotiated by apprehensive patients in whom is implanted the notion that any surgeon who would propose *this* operation should be automatically questioned. Inevitably, the process leads to speculation whether such a surgeon should be entrusted to *any* extent with one's life and well-being.

Many centers are working on finding a cure. Once again, those who primarily focus on finances in preference to quality of outcome will be favored by the selection afforded by this disease.

With the best of intentions, the rules of medicine have again been altered to favor the mendacious rather than the caring.

NORMAN J. HARRIS, MD
500 S Anaheim Hills Road, Suite 240
Anaheim, CA 92807

California Legislation to Inform Patients

TO THE EDITOR: Regarding your editorial "How About Some Affirmative Action for Patient Advocacy?" in the April issue,[1] I believe that the readers of the journal should be aware that efforts are being made in the interest of our patients. One of the greatest threats to the role of physicians as patients' advocates are those systems of health-care delivery that utilize the gatekeeper concept. Those physicians who act as gatekeepers clearly must align themselves with the interests of the health maintenance organization (HMO) that employs them. At times, this means the restriction of health-care services, even when others may attest to the need for such services. Unfortunately, many slick marketing techniques fail to inform those persons who enroll in such systems that they may lose their free choice of physician. To this end, the California Congress of Dermatological Societies proposed a resolution which the California Medical Association House of Delegates passed and which has since been proposed as California Assembly Bill 2967. As introduced it would have required that any descriptive material used by health-care delivery systems must prominently include a statement advising that participation in such plans will restrict the free choice of physician and hospital. Now amended, it would call the attention of prospective enrollees to detailed materials that clearly describe how the plan would affect choice of physician.

We physicians must do all we can to help our patients. This bill may be just the sort of advocacy that the editorial referred to. If other readers in California are in favor of it, I hope that they contact their legislators.

ALLAN S. WIRTZER, MD
15211 Vanowen St, Suite 206
Van Nuys, CA 91405

REFERENCE

1. Watts MSM: How about some affirmative action for patient advocacy? (Editorial). West J Med 1986 Apr; 144:458

Patient Advocacy

TO THE EDITOR: Your editorial on patient advocacy in the April issue[1] addresses a most important and strangely neglected subject. In this area of patient representation there is a conspicuous void.

I have recently written an "educational" letter to my patients about some of the ongoing and proposed changes in medical care (insurance) programs. The response was quite strong. But when patients ask me who there is to represent their needs in formulating these new programs, I don't know how to answer. Many patients are most anxious to support any advocates who will try to protect their health and preserve and improve their health care; but where are these advocates? They speak up with silence.

Legislators are not interested now in improving health care programs, but only in lowering costs. Physicians in practice, involved in direct patient care and trying to survive the economics of the new plans, are very little involved in the design of these new plans to serve patients. Organized medicine seems to have its hands full helping its member physicians, not acting as patient advocates.

Must lowering costs mean ignoring patients' medical care needs? Not completely. But few doctors, or very many others who represent patients and understand their medical requirements, are involved in designing the lower cost programs, with service to and protection of individual patients in mind. Individual physicians may make heroic efforts to protect individual patients from being hurt by a particular administrative "crack" in a single insurance plan. This will help very little, in spite of all the effort. The insurance plan itself must be changed. Physicians who know how to take care of patients must act as consultants as all these new plans are developed and revised. This is certainly not done presently.

Ours is a noble profession. Economic pressures must not divert our attention from the health of our public. We also cannot survive if we use our resources only to protect ourselves rather than to provide care for our patients.

A large job needs to be done. There are extra physicians around everywhere. Let's get busy.

GEORGE E. GOURRICH, MD
2080 Century Park East, Suite 704
Los Angeles, CA 90067

REFERENCE

1. Watts MSM: How about some affirmative action for patient advocacy? (Editorial). West J Med 1986 Apr; 144:458